STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		DDIC	00	COMPL	ETED
			A. BUII B. WIN			08/13/	2014
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIEF	₹			10TH ST		
DDIDCE	AT GARDEN PLAZ	7.0			APOLIS, IN 46234		
BRIDGE	AT GARDEN PLAZ	LA .		INDIAN	APOLIS, IN 46234		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
R000000							
	This visit was fo	or the Investigation of	R00	0000	Responses to the cited		
	Complaint IN00	_			deficiencies do not constitute a	an	
	Complaint 11400	117302.			admission or agreement b the		
					provider of the truth of the fact	S	
	•	149302 - Substantiated.			alleged or conclusions set fort	h in	
	State deficiencie	es related to the			the Statement of Deficiencies.		
	allegations are c	ited at R121,R406, and			The Plan of Correction is		
	R410.				prepared solely as a matter of		
	TC110.				compliance with Federal and		
	D . 00				State Law.		
	Date of Survey:						
	August 13, 2014	ļ					
	Facility number:	005616					
	Provider number						
	AIM number: N	NA					
	Survey Team:						
	Mary Jane G. Fi	scher RN					
	Census bed type						
	• •	·					
	Residential: 87						
	Total: 87						
	Census payor ty	pe:					
	Other: 87	•					
	Total: 87						
	101.07						
	Sample: 6						
	Supplemental sa	imple: 9					
	These state findi	ings are cited in					
		410 IAC 16.2-5.					
	accordance with	710 IAC 10.2-3.					
LABORATOR	Y DIRECTOR'S OR PRO	VIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE STORY	GNATURI	3	TITLE		(X6) DATE

Any defiencystatement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/30/2014 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		ĺ	LDING	NSTRUCTION  00	(X3) DATE COMPL 08/13/	ETED	
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE  8614 W 10TH ST INDIANAPOLIS, IN 46234				
				<u> </u>	AI OLIO, IIV 40204		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES  CY MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
	-	was completed by N on August 14, 2014.					
R000121	employee of a faci contact. The screet tuberculin skin test method (5 TU, PP) positive reaction or result shall be reconstruction with the and by whom admassure the followin (1) At the time of equation (1) month prior to annually thereafted personnel of facilit tuberculosis. The famust be read prior work. For health can had a documented test result during the months, the baselist should employ the first step is negative be performed one after the first step. testing will depend with tuberculosis. (2) All employees reaction to the skir have a chest x-ray	ompliance shall be required for each lity prior to resident shall include a t, using the Mantoux D), unless a previously an be documented. The orded in millimeters of date given, date read, inistered. The facility must					

State Form Event ID: 8BX611 Facility ID: 005616 If continuation sheet Page 2 of 21

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED	
			B. WING		08/13/2014	
NAME OF I	PROVIDER OR SUPPLIE	R	STREET	ADDRESS, CITY, STATE, ZIP CODE	•	
TWINE OF	NO VIDER OR SULLED	· ·		V 10TH ST		
BRIDGE	AT GARDEN PLAZ	ZA	INDIAN	NAPOLIS, IN 46234		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
		all maintain a health record				
		e that includes reports of all ed health screenings.				
	1	with symptoms or signs of				
		ymptoms suggestive of				
		s, including, but not limited				
		night sweats, and weight				
	loss) shall not be tuberculosis is rul	permitted to work until				
		l review and interview the	R000121	System: New hires will not be	gin $09/12/2014$	
		ensure tuberculin skin	1000121	work without completing the T	0 / 1 = / = 0 1 .	
	_	pleted at the time of		test requirements prior to new		
				hire orientation. Current		
		d annually for 10 of 22		employees will receive an		
		reviewed. (Employees #7,		updated TB test at the time of their annual evaluation as wel		
		2, #13, #14, #15, #16,		a TB test list will be established		
	and # 17)			and test given at the monthly		
				mandatory all staff meeting fo		
	Findings include	e:		those who staff members who		
				may have been on vacation o to maintain compliance.	· ""	
		ee files were reviewed on		Monitoring: The Human Reso	urce	
		p.m. The following was		Director will be responsible fo	r	
	_	to the facility's lack of		monitoring compliance on a		
	tuberculin testin	g at the time of		weekly basis. The General Manager will monitor complian	200	
	employment, an	nual tuberculin testing		monthly at the end of the all s		
	and risk assessn	nents for those employee's		meeting to verify compliance.		
	determined to be	e reactors to the Mantoux		list of employees due for PPD		
	method.			given out weekly with their		
				evaluation at the leadership		
	Employee #7 - I	Receptionist - hired on		meeting to the appropriate supervisors. A new employ	ee	
		view of the employee		has been hired to replace the		
		related to tuberculin		previous staff member who di		
		I the last skin test was		not meet state compliance. A		
	performed 03-1			complete employee file audit v		
	portorniou 05-1			completed on August 28,2014 All employees who were not it		
	Employee #0	Server - hired on		compliance did receive a TB t		
				to ensure compliance. A syst		
	1 12-10-05. The 6	employee file contained	1	1		

State Form Event ID: 8BX611 Facility ID: 005616 If continuation sheet Page 3 of 21

B. WING 08/13	3/2014
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  8614 W 10TH ST	
BRIDGE AT GARDEN PLAZA INDIANAPOLIS, IN 46234	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDERS PLAN OF CORRECTION  PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY)	(X5) COMPLETION DATE
has been established for annual reviews and TB testing, new hires will not be allowed to start work until the TB testing requirement is met. The HRIPayroll employee is responsible for one state compliance and the General Manger will monitor for state compliance.  The Annual Risk assessments were dated 12-06-05, 08-28-07, 12-19-07, 08-13-08, 07-28-09, and an authorization form for a chest x-ray were in the employee record), a risk assessment dated 08-02-11, and 08-30-12. The record lacked documentation the employee had a reaction to the tuberculin testing and lacked risk assessments for the years 2013 and 2014.  Employee #10 - LPN (Licensed Practical Nurse) - hired on 05-19-14. The employee file contained a "TB [Tuberculosis] Information, Consent and Questionnaire," dated 05-01-14. The record lacked tuberculin testing prior to employment.  Employee #11 - CNA (Certified Nurses Aide) - hired 03-15-12. The employee file indicated this CNA received tuberculin testing by the two step method. Step one was given on 03-12-12 and read on 03-14-12. The instructions on this form prompted the nurse that "Step two - TB test is to be done within 4 - 10 days of first step." Step two was conducted on 03-26-12 and read on 05-16-12 and read on 05-16-12 and read on 05-16-13 and can be done within 4 - 10 days of first step." Step two was conducted on 03-26-12 and read on 05-16-17 and read on 05-16-18 and reviews and TB testing, we hires will not be allowed to start work until the TB testing reviews and TB testing, we hires will not be allowed to start work until the TB testing reviews and TB testing not be altowed to start work until the TB testing reviews and TB testing reviews will not kent took.	DATE

State Form Event ID: 8BX611 Facility ID: 005616 If continuation sheet Page 4 of 21

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CO  A. BUILDING  B. WING	00	COMI	E SURVEY PLETED 3/2014
	PROVIDER OR SUPPLIEF		8614 W	ADDRESS, CITY, STATE, ZIP C 110TH ST APOLIS, IN 46234	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	04-08-13. The f	next testing was 1-06-13 and "read" on Tile lacked tuberculin assessment for 2014.				
	The employee fi Information, Co. dated 04-23-14.	CNA - hired 04-28-14. le contained a "TB nsent and Questionnaire," The record lacked g prior to or since the nent.				
	"Tuberculosis So 08-25-08, a ches results which ind pulmonary disea	employee file contained a creening," dated st x-ray on 08-20-09 with dicated "no active use," "screenings" dated -11, 11-21-12 and file lacked any				
	Medication Aide file contained a Consent and Questionnai form was signed	QMA (Qualified e) - hired 04-01-12. The "TB Information, estionnaire," dated finitial - first step testing -12 and read on second step tuberculin d 06-13-12. The file Information, Consent re," dated 04-08-14. The land dated by the e "questionnaire" had not				

State Form Event ID: 8BX611 Facility ID: 005616 If continuation sheet Page 5 of 21

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		LDING	00 	COMPL 08/13/	ETED	
	ROVIDER OR SUPPLIER		STREET A	ADDRESS, CITY, STATE, ZIP CODE 10TH ST APOLIS, IN 46234		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE
IAG	been completed to the employee protein derivative employee had tear record lacked tube employment, or a testing for 2014.  Employee #15 - The record contatuberculosis test, testing was late. contained a "TB and Questionnain 03-25-13, with A 09-12-12 and 03 lacked tuberculing assessment for 20 Employee #16 - The file indicated two step method 03-05-12. The second-contact two steps method 03-05-12 and rear 04-08-13 a "TB I Questionnaire," Annual PPD log received the testinext Annual testing was Employee #17 - Emp	by the QMA. A review "Annual PPD [purified e] Log," indicated the sting on 04-08-13. The perculin testing prior to the risk assessment or  QMA - hired 04-16-09. ined an "annual " dated 08-18-10. This The employee file Information, Consent re," dated 09-12-12 and annual PPD tests on -25-13. The record in testing or a risk 014.  QMA - hired 03-26-09. In the employee had the on 03-02-12 and read on econd step was dated and on 03-26-12. On Information, Consent and was completed and the indicated the employee ing on 04-08-13 and the ing was dated 07-09-14. late.  Cook - hired on	IAG			DATE
	04-15-13. The fi	ile contained the "TB nsent and Questionnaire,"				

State Form Event ID: 8BX611 Facility ID: 005616 If continuation sheet Page 6 of 21

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CC  A. BUILDING  B. WING	00	COMP	ESURVEY LETED 3/2014	
	PROVIDER OR SUPPLIER		STREET A 8614 W	ADDRESS, CITY, STATE, ZIP CO 10TH ST APOLIS, IN 46234	DDE	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) The Initial and second	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	received the first	ted the employee a step on 04-02-13, and 3. The second step was 13. The file lacked a risk sting for 2014.				
	p.m., the Director was aware of the employees not b tuberculin testing are new here and Resources Direct planning an all s	iew on 08-13-14 at 2:00 or of Nurses indicated she problem with the eing up to date with g. "All department heads I the HR (Human tor) just started. We are taff Inservice on August we will have to get then."				
	08-13-14 at 1:40 "Tuberculosis (T	B) Screening for dated August 2011,				
	safety and well-l	omote resident/associate being by screening aberculosis (TB) and riate follow-up."				
	All associates ar	B) at upon hire, annually				

State Form Event ID: 8BX611 Facility ID: 005616 If continuation sheet Page 7 of 21

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			LDING	00 	COMPL 08/13/	ETED	
	ROVIDER OR SUPPLIER AT GARDEN PLAZ		STREET ADDRESS, CITY, STATE, ZIP CODE  8614 W 10TH ST INDIANAPOLIS, IN 46234				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	who have been more employment was presence of infect [Mycobacterium] Mantoux PPD [presence] derivative] skin to employ the two so Individuals with a positive PPD was testing. They will to bring document physician or local their work up fol Individuals with of a PPD skin test months will under procedure."  "Annual Associates with a history will have annual PPD skin test results, will be seen to see the procedure."	Tuberculosis using the urified protein esting. Skin testing will step procedure. 2. a documented history of will not undergo skin ll, however, be required nation from their private all health department of lowing conversion. 5. no documented history at within the last 12					
R000406	410 IAC 16.2-5-12	(a)					

State Form Event ID: 8BX611 Facility ID: 005616 If continuation sheet Page 8 of 21

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:	A. BUILDING 00	COMPLETED	
	B. WING	<del></del>	
	STREET ADDRESS, CITY, STATE, ZIP C	CODE	
NAME OF PROVIDER OR SUPPLIER	8614 W 10TH ST		
BRIDGE AT GARDEN PLAZA	INDIANAPOLIS, IN 46234		
		l gre	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES	ID PROVIDER'S PLAN OF COR PREFIX (EACH CORRECTIVE ACTION S		
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL	CROSS-REFERENCED TO THE	APPROPRIATE COM EL TION	
· · · · · · · · · · · · · · · · · · ·	IAG DEFICIENCE)	DATE	
Infection Control - Offense  (a) The facility must establish and maintain an infection control practice designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of diseases and infection.  Based on record review and interview the facility failed to ensure an effective infection control program in that the facility failed to ensure timely Mantoux testing for current residents (Resident's "A", "D" and "E") and provide tuberculin skin testing for employees at the time of employment and annually. (Employees #7, #8, #9, #10, #11, #12, #13, #14, #15 and #16). The facility failed to incorporate a system to ensure effective monitoring of testing for resident's and employees.  This deficient practice had the potential to effect 87 of 87 current resident's and 102 of 102 current employees.  Findings include:  1a. The record for Resident "A" was reviewed on 08-13-14 at 9:30 a.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease, oxygen dependent, lung cancer and Alzheimer's dementia. These	R000406  An immediate resident was completed on Aug 14,2014. All TB Testir with residents to meet standard. A monthly Taudit will be completed of the month with rewr verify constant complia reaction greater than 1 be noted by the MD,Cl taken and any allergy noted on the chart. The Care Director is respondent of the month will monitor of compliance. The Gen Manager will monitor of compliance.	t chart audit gust ng is current the State Testing d at the end ites to ance. Any 10 mm will hest xray will be ne Resident nsible for eral	
Findings include:  1a. The record for Resident "A" was reviewed on 08-13-14 at 9:30 a.m.  Diagnoses included, but were not limited to, chronic obstructive pulmonary disease, oxygen dependent, lung cancer			

State Form Event ID: 8BX611 Facility ID: 005616 If continuation sheet Page 9 of 21

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY  COMPLETED  08/13/2014	
	PROVIDER OR SUPPLIE		8614 W	ADDRESS, CITY, STATE, ZIP CODE 7 10TH ST APOLIS, IN 46234	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	admitted to the	facility on 07-14-2010.			
	tuberculin log ir tuberculin testin 07-22-11 and 07	resident's annual adicated the resident had ag on 07-19-10, 08-02-10, 7-20-12. The resident arrent risk assessment or ag.			
	reviewed on 08-Diagnoses incluto, congestive hobstructive pulning hypertension, ceand anemia. The current at the tire	for Resident "D" was -13-14 at 10:00 a.m. ded, but were not limited eart failure, chronic nonary disease, erebral vascular accident lese diagnoses remained me of the record review. s admitted to the facility			
	tuberculin log ir tuberculin testin	resident's annual adicated the resident had ag on 01-31-13 and then the testing for the resident			
	a.m., the Directo	view on 08-13-14 at 11:05 or of Nurses indicated the have been tested in			
	reviewed on 08-	for Resident "E" was -13-14 at 11:45 a.m. ded, but were not limited			

State Form Event ID: 8BX611 Facility ID: 005616 If continuation sheet Page 10 of 21

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CC  A. BUILDING  B. WING	00	COMPLETED  - 08/13/2014	
	PROVIDER OR SUPPLIER		STREET A 8614 W	ADDRESS, CITY, STATE, ZIP CO 1 10TH ST APOLIS, IN 46234	DDE
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE COMPLETION
	hypertension and diagnoses remain the record review admitted to the f	ver extremity edema, d osteoporosis. These ned current at the time of v. The resident was acility on 09-08-12.			
	indicated a first s completed on 09 "0 mm [millimet was completed of resident's result v x-ray was ordered	resident tuberculin log step Mantoux was -10-12. The result was ers]." A second step test on 09-26-12. The was "10 mm." A chest ed and completed on a assessment was -26-14.			
	resident's physic	e resident after a positive			
	following was not facility's lack of time of employn testing and risk a	13-14 at 1:00 p.m. The oted in regard to the tuberculin testing at the ment, annual tuberculin assessments for those rmined to be reactors to			
	03-17-11. A rev documentation r	deceptionist - hired on liew of the employee elated to tuberculin the last skin test was			

State Form Event ID: 8BX611 Facility ID: 005616 If continuation sheet Page 11 of 21

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			LDING	00	COMPL 08/13/	ETED	
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	ROVIDER OR SUPPLIER			8614 W	10TH ST		
BRIDGE	AT GARDEN PLAZ	Α		INDIAN	APOLIS, IN 46234		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	· ·	CY MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETION DATE
TAG	performed 03-11	·		TAG	BETTELLITE		DATE
	periorinea 03-11	-13.					
	Employee #9 - S	erver - hired on					
		mployee file contained					
	the results of a c	• •					
	07-31-03 - two y	•					
	employment.	1					
		assessments were dated					
	12-06-05, 08-28-	-07, 12-19-07, 08-13-08,					
	07-28-09, and ar	authorization form for a					
	chest x-ray dated	1 08-19-09 (no results of					
	the chest x-ray w	vere in the employee					
	record), a risk as	sessment dated					
	08-02-11, and 08	3-30-12. The record					
	lacked document	tation the employee had a					
	reaction to the tu	berculin testing and					
	lacked risk asses	sments for the years					
	2013 and 2014.						
		LPN (Licensed Practical					
	Nurse) - hired or						
	employee file co						
		nformation, Consent and					
		dated 05-01-14. The					
		perculin testing prior to					
	employment or s	since the date of					
	employment.						
	F1 //11	CNIA (Cartifical N					
		CNA (Certified Nurses					
	file indicated this	15-12. The employee					
		g by the two step					
	_	the was given on 03-12-12 4-12. The instructions					
	and read on 03-1	4-12. THE INSULCTIONS					

State Form Event ID: 8BX611 Facility ID: 005616 If continuation sheet Page 12 of 21

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING	00	COMPLETED	
			B. WING		08/13/2014
NAME OF I	DDOMINED OD GUIDDI TED		STREET	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIER		8614 V	V 10TH ST	
	AT GARDEN PLAZ			NAPOLIS, IN 46234	·
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL	PREFIX	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCE)	DATE
	_	mpted the nurse that			
	•	est is to be done within 4			
	1	step." Step two was			
		-26-12 and read on			
	03-28-12. The n	•			
	•	-06-13 and "read" on			
		ile lacked tuberculin			
	testing or a risk a	assessment for 2014.			
	Employee #12 -	CNA - hired 04-28-14.			
	1 2	le contained a "TB			
		nsent and Questionnaire,"			
		The record lacked			
		g prior to or since the			
	date of employm				
	date of employing	ient.			
	Employee #13 -	CNA - hired on			
	09-02-02. The e	employee file contained a			
	"Tuberculosis So				
		t x-ray on 08-20-09 with			
	· ·	dicated "no active			
		se," "screenings" dated			
		-11, 11-21-12 and			
	08-13-14. The f	-			
	documentation f	•			
	Employee #14 -	QMA (Qualified			
		e) - hired 04-01-12. The			
		"TB Information,			
		estionnaire," dated			
	-	·			
		initial - first step testing			
	was dated 05-30				
		econd step tuberculin			
	testing was dated	d 06-13-12. The file			

State Form Event ID: 8BX611 Facility ID: 005616 If continuation sheet Page 13 of 21

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CO A. BUILDING B. WING	00	COMI	E SURVEY PLETED 3/2014		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE  8614 W 10TH ST INDIANAPOLIS, IN 46234					
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) Information, Consent	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE		
	and Questionnai form was signed employee but the been completed of the employee protein derivative employee had te record lacked tule employment, or testing for 2014.  Employee #15 - The record contatuberculosis test.	re," dated 04-08-14. The and dated by the e "questionnaire" had not by the QMA. A review "Annual PPD [purified the legal Log," indicated the sting on 04-08-13. The berculin testing prior to the risk assessment or QMA - hired 04-16-09.						
	contained a "TB and Questionnai 03-25-13, with A 09-12-12 and 03	Information, Consent re," dated 09-12-12 and Annual PPD tests on -25-13. The record in testing or a risk						
	The file indicate two step method 03-05-12. The s 03-23-12 and rea 04-08-13 a "TB Questionnaire," Annual PPD log received the test	QMA - hired 03-26-09. d the employee had the on 03-02-12 and read on econd step was dated ad on 03-26-12. On Information, Consent and was completed and the indicated the employee ing on 04-08-13 and the ing was dated 07-09-14. late.						

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE COMPL		
ANDFLAN	OF CORRECTION	IDENTIFICATION NUMBER.		LDING	00	08/13/	
			B. WIN			00/13/	2014
NAME OF F	ROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP CODE  10TH ST		
BRIDGE	AT GARDEN PLAZ	'A			APOLIS, IN 46234		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
	Employee #17 - 04-15-13. The finformation, Condated 04-02-13. step form indicarreceived the first read on 04-05-13 given on 04-29- assessment or terms. During an int 2:00 p.m., the Dindicated she was with the employ with tuberculin theads are new here Resources Direct planning an all step 26th (2014) and everyone tested 4. During an int 11:15 a.m., the I indicated "I start	Cook - hired on file contained the "TB insent and Questionnaire," The Initial and second ted the employee it step on 04-02-13, and in the second step was in the second step was in the file lacked a risk sting for 2014.  The file lacked a risk sting for 2014.  The review on 08-13-14 at in the interior of Nurses is aware of the problem in the second step was in the s					
	•	nths. I'm not surprised					
	•	of problems with the					
	PPD's [purified protein derivative]. It						
	seems that prior started an audit.'	to me coming they					
	5. A review of t	he facility policy on					
	08-13-14 at 1:45	p.m., titled					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MU A. BUILI B. WING	DING	NSTRUCTION 00	(X3) DATE COMPL 08/13/	ETED	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE  8614 W 10TH ST INDIANAPOLIS, IN 46234					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX (EACH CORRECTIVE ACTION SHOU		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	LD BE COMPLETIO		
IAU	"Tuberculosis Co August 2011, ind "Purpose - to minexposure to and with Tuberculosi "Policy -This con will enforce the of the Center for Prevention (CDO of occupational to among it's associate "Administrative responsibility. For the responsibility. For the responsibility. For the responsible for in Tuberculosis Co "Risk Assessment will be conducted community's risk and to direct the be implemented. The retrospective risk conducted by concalendar year."  "A group of quality involved in initiation assessment. It we community as a shealthcare staff as	ontrol Plan," dated dicated the following: nimize associate subsequent infection is (TB)."  mmunity has adopted and datest recommendations Disease Control and C) regarding prevention transmission of TB dates."  Controls - assignment of Resident Care Director is mplementation of antrol Program."  nt - A risk assessment dinitially to assess a for transmission of TB TB control measure to		IAU			DATE	
			l .				l	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING	00	(X3) DATE SURVEY COMPLETED 08/13/2014			
			B. WING		00/13/2014		
	PROVIDER OR SUPPLIER AT GARDEN PLAZ		STREET ADDRESS, CITY, STATE, ZIP CODE  8614 W 10TH ST INDIANAPOLIS, IN 46234				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
	staff PPD test scr TB resident med	e, Analysis of healthcare reening data, review of ical records"  g relates to Complaint					
R000410	completed within the admission or upon forty-eight (48) to so the result shall be induration with the and by whom admit (f) For residents with documented negatives and the performed with the performed with weeks after the first repeat testing will infection with tube (g) All residents with the tuberculin sittle to have a chest x-informed with the tuberculin sittle to have a chest x-informed with the tuberculin sittle to have a chest x-informed with the tuberculin sittle to have a chest x-informed with the tuberculin sittle to the tuberculin sittle to the tuberculin sittle tuberculi	Noncompliance uberculin skin test shall be hree (3) months prior to admission and read at seventy-two (72) hours. recorded in millimeters of date given, date read, inistered and read. ho have not had a tive tuberculin skin test receding twelve (12) ne tuberculin skin testing two-step method. If the ve, a second test should in one (1) to three (3) st test. The frequency of depend on the risk of					
	Based on record facility failed to tuberculin testing resident's physical assessment of a positive PPD [pu	resident who had a urified protein derivative] and resident's. (Residents	R000410	An immediate resident chart a was completed on August 14,2014. All TB Testing is cur with residents to meet the Stat standard. A monthly Testing audit will be completed at the of the month with rewrites to verify constant compliance. A reaction greater than 10 mm with be noted by the MD, Chest xra	rent te end ny		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE O	(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENT		IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		B. WING		08/13/2014	
				ADDRESS, CITY, STATE, ZIP CODE	<u> </u>
NAME OF P	PROVIDER OR SUPPLIEF	t .		W 10TH ST	
	AT GARDEN PLAZ	ZA .	INDIA	NAPOLIS, IN 46234	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	1 11 7	DATE
	F: 1: : 1 1			taken and any allergy will be noted on the chart. The Residual	dent
	Findings include	): 		Care Director is responsible for	
	1 771 1.0	D 11		compliance. The General	
		or Resident "A" was		Manager will monitor monthly	for
		13-14 at 9:30 a.m.		compliance.	
	_	ded, but were not limited			
		uctive pulmonary			
	disease, oxygen	dependent, lung cancer			
	and Alzheimer's	dementia. These			
	diagnoses remain	ned current at the time of			
	the record review	w. The resident was			
	admitted to the f	acility on 07-14-2010.			
	A review of the	resident's annual			
	tuberculin log in	dicated the resident had			
		g on 07-19-10, 08-02-10,			
		-20-12. The resident			
		risk assessment or			
		g for 2013 and 2014.			
	tuocieum testin	g 101 2013 unu 2014.			
	2. The record for	or Resident "D" was			
	reviewed on 08-	13-14 at 10:00 a.m.			
	Diagnoses inclu	ded, but were not limited			
	_	eart failure, chronic			
	obstructive pulm	*			
	•	rebral vascular accident			
	and anemia. These diagnoses remained current at the time of the record review.				
	The resident was admitted to the facility on 01-31-13.				
	OII 01-31-13.				
	A review of the	resident's annual			
		dicated the resident had			
	_				
	tuberculin testing	g on 01-31-13 and then	1		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CO  A. BUILDING  B. WING	00	COM	te survey ipleted 13/2014		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE  8614 W 10TH ST INDIANAPOLIS, IN 46234					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE API DEFICIENCY)	ULD BE	(X5) COMPLETION DATE		
	on 07-28-14. The was late.	ne testing for the resident						
	a.m., the Directo	riew on 08-13-14 at 11:05 or of Nurses indicated the have been tested in						
	reviewed on 08-Diagnoses included to, dementia, low hypertension and diagnoses remains the record review admitted to the formula of the record review admitted to the record rec	or Resident "E" was 13-14 at 11:45 a.m. ded, but were not limited wer extremity edema, d osteoporosis. These ned current at the time of w. The resident was facility on 09-08-12.						
	indicated a first completed on 09 "0 mm [millimet was completed of resident's result x-ray was ordered	resident tuberculin log step Mantoux was 0-10-12. The result was ters]." A second step test on 09-26-12. The was "10 mm." A chest ed and completed on k assessment was 0-26-14.						
	resident's physic	e resident after a positive						
		terview on 08-13-14 at Director of Nurses						

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CO  A. BUILDING  B. WING	NSTRUCTION 00	COM	TE SURVEY MPLETED 13/2014		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 8614 W 10TH ST INDIANAPOLIS, IN 46234					
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SF CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE		
	prior to me there Nurses for 9 mo	ted in May [2014] and e was no Director of nths. I'm not surprised ags a pattern of problems						
	08-13-14 at 1:45 "Tuberculosis C August 2011, in  "Administrative responsibility. I	ontrol Plan," dated dicated the following: Controls - assignment of Resident Care Director is mplementation of						
	will be conducted community's risk	nt - A risk assessment ed initially to assess k for transmission of TB TB control measure to						
	- 1. All first tim screened for infer bacilli prior to me requirements. 2 will consist of a using 5 units of intercutaneously history of skin to screened by a chaphysician's clinic proper documents.	Residents with a est positively will be						

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/30/2014 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES  AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	LTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL B. WING		00	COMPLETED 08/13/2014	
				_	DDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIEF	8			10TH ST		
BRIDGE AT GARDEN PLAZA				INDIAN	APOLIS, IN 46234		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PRECEDED BY FULL	I	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	test positive resi	dents will have physician					
	follow-up by do	cumentation regarding					
	presence or abse	nce of symptoms					
	consistent with	ГВ."					
	This State finding relates to Complaint IN00149302.						
<u> </u>	1		•				1

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